PRACTICE RECOMMENDATIONS
Diabetes Mellitus: type 1 and type 2

PROCEDURE	FREQUENCY	ACTION
A. PRACTICING THE ABC'S OF DIABETES MANAGEMENT		
A1C Formerly referred to as Hemoglobin A1c, or HbA1c	At least twice a year	Normal: <6.0% Goal: <7.0% (ADA), < 6.5% (AACE) Action: If ≥ 7.0%
BLOOD PRESSURE SCREENING	Every office visit	If BP >130/80 If BP >125/75 in the presence of diabetic nephropathy
CHOLESTEROL (LIPID PROFILE)	Annually. If lipid levels within target guidelines for two consecutive years, may decrease frequency to every 2 years.	If LDL >100 mg/dl, or If HDL <40 mg/dl (men), or <50 mg/dl (women), or If TG >150 mg/dl
B. SCREENING FOR COMPLICATIONS		
COMPLETE FOOT EXAM Including visual inspection and neurovascular examination	At least once a year	Sensory testing with a 5.07 (10 gm) nylon monofilament, applied perpendicularly until monofilament buckles. Loss of protective sensation (LOPS) exists if no perception present at ≥1 site (plantar surface of 1st or 5th toes, or 1st, 3rd, or 5th metatarsal heads).
COMPREHENSIVE EYE EXAM (including Dilated Eye Exam) by an ophthalmologist or optometrist knowledgeable and experienced in diagnosing diabetic retinopathy.	**type 1:** Annually beginning 5 years after onset. **type 2:** Annually beginning at diagnosis. **Pregnancy:** Women with preexisting diabetes should have a comprehensive eye exam if planning a pregnancy and/or during 1st trimester.	If diabetic retinopathy is detected, follow-up referral to an ophthalmologist who is knowledgeable and experienced in treating diabetic retinopathy.
EARLY NEPHROPATHY DETECTION Urine Microalbumin	**type 1:** Annually beginning 5 years after onset. If gross proteinuria is present earlier, see Appendix. **type 2:** Annually beginning at diagnosis.	1. If microalbuminuria or gross proteinuria is detected and confirmed, begin treatment with ACE inhibitor (type 1); ACE inhibitor or ARB (type 2). 2. If albuminuria persists on ACE inhibitor or ARB, consider combination ACE inhibitor plus ARB therapy to further reduce albuminuria. 3. Microalbuminuria and/or GFR <60 are independent risk factors for cardiovascular disease. If detected, reduction of all modifiable risk factors strongly advised.
DEPRESSION SCREENING Using a validated self-report instrument (see Appendix), either upon check-in for visit or in office/exam room.	At least twice a year	If score on depression instrument falls in the range for depression, referral to a behavioral health specialist (see Appendix) for further assessment and treatment recommendations.
C. PREVENTIVE MEASURES		
FLU IMMUNIZATION	Annually	Administer in the fall (October is optimal)
PNEUMOCOCCAL IMMUNIZATION	At diagnosis if not already vaccinated	Revaccinate if patient ≥65 AND first vaccination was more than 5 years ago when patient was 64 years or younger.
ASPIRIN PROPHYLAXIS	In patients ages 21-39 with cardiovascular risk factors and in all patients ≥40 years if no contraindications.	Low dose 75-162 mg/day
TOBACCO USE ASSESSMENT	**Smokers:** Ask and advise at every visit. **Non-smokers:** Ask and advise at diagnosis and annually thereafter.	1. **Ask** and identify tobacco use. 2. **Advise** patient of importance of quitting. 3. **Assess** patient interest in quitting 4. **Assist** the patient in quitting (pharmacologic therapy, referral, etc.) (see Appendix) 5. **Arrange** for follow-up contact soon after quit date.
ORAL/DENTAL EXAMINATION Evaluation of teeth and soft tissue of the mouth.	Optimally every 6 months, but at least annually.	Oral prophylaxis at least annually.
D. DIABETES EDUCATION & SELF-MANAGEMENT TRAINING		
DIABETES EDUCATION Provided by a registered, licensed, or certified health professional, preferably a CDE.	At diagnosis and annually thereafter	Individual or group instruction, based on assessment. Refer when regimen is changed or when not achieving adequate control.
MEDICAL NUTRITION THERAPY Individual MNT as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT.	At diagnosis, with follow-up as needed until initial goals are met, then at 6-month to 1-year intervals as needed. Children may need more frequent follow-up, e.g., every 3 months.	1. Reasonable weight, or, in children, appropriate growth and development, are not maintained. 2. Food intake is not balanced with drug therapy and/or exercise. 3. Patient expresses desire for nutrition information.
SELF-MONITORING OF BLOOD GLUCOSE	Should be encouraged in all patients and should be individualized to help reach and maintain treatment goals.	SMBG logs should be reviewed at all regularly scheduled diabetes visits.
PHYSICAL ACTIVITY People with diabetes may benefit from an exercise program but should be assessed for risks and benefits prior to engaging in moderate to strenuous exercise.	Discuss at every visit	Goal: 30 minutes moderate activity on all or most days of the week. See Appendix.
E. WOMEN AND DIABETES		
PRECONCEPTION COUNSELING	At time of initial visit in all women of childbearing potential or upon reaching childbearing age.	See Appendix
GESTATIONAL DIABETES Any degree of glucose intolerance with onset or first recognition during pregnancy.	**Pregnant:** All women, especially those with risk factors and those with previous gestational diabetes, should be screened at 24 to 28 weeks' gestation. (see Appendix) **Postpartum:** Test at ≥ 6 weeks' postpartum and if normal, test annually for at least 3 years.	**Pregnant:** Those identified with gestational diabetes should be managed by physicians trained and experienced in treating gestational diabetes. **Postpartum:** Those with impaired glucose tolerance or diabetes should be treated appropriately. Those with persistent glucose elevations not responsive to diet alone should be maintained on insulin if they are breast-feeding.
F. EMERGING ISSUES		
PREDIABETES A condition that includes impaired glucose tolerance (IGT) and impaired fasting glucose (IFG). IGT: Oral Glucose Tolerance Test (OGTT) 2-h post load glucose 140-199mg/dl IFG: Fasting Blood Glucose 100-125mg/dl	At each new patient encounter consider the diagnosis of prediabetes.	Patients with prediabetes should be counseled regarding measures to prevent diabetes (especially diet and exercise) and cardiovascular risk factors should be addressed and managed appropriately.
DISABILITY Defined as an impairment that substantially limits one or more major life activities.	At each visit, assess for functional and activity limitations.	Referral to appropriate specialist, agency, or organization as needed.